APPENDIX C (STATEMENT OF WORK EXHIBITS)

ATTACHMENT 1

PERFORMANCE REQUIREMENTS SUMMARY CHART

The Performance Requfrements Summary (PRS) Chart is a lisit ng of the minimum required services and performance that will be monitored duri'ng the Contract term. The PRS chart also lists examples of the types of documents that will be used dunng momtoring, as well as the standards of performance and the acceptable quality level of performance.

All listings of reqUired serv1ces or standards used in th1s Performance Requirements Summary Chart are Intended to be completely cons1stent w1th the terms and condft1ons of the Contract (Appendix A of the RFP) and the Statement of Work (Exhibit A to the Contract and Appendix B of the RFP) and are not meant 1n any case to create, extend, rev1se, or expand any obligation of the Contractor beyond that definedin the terms and conditions of th1s Contract and Statement of Work. In any case of apparent inconsistency between required serv1ces or Standards as stated in the terms and conditions of the Contract, the Statement of Work, and th1s Performance Requirements Summary (PRS) Chart, the terms and cond11ions of the Contract and the Statement of Work (SOW) Will prevail.

Performance Outcomes	Standards	Acceptable Quality Level	Data Source	Remedies For Non-Compliance
Percentage of Supportive Services Program (SSP) registered Clients that exit the program because the Client no longer desires Services.	95% of SSP Clients that exit the program because they no longer need or desire the Services.	100%	MIS Reports	If Contractor performance does not meet the Acceptable Quality Level, the County will have the option to apply the following remedies: 1) Corrective Action Plan; 2) Suspension of Payment; 3) Suspension of Contract; 4) Reduce and reallocate funds; and 5) Termination of Contract.
Unduplicated Client Count for SSP Services with all mandated demographic fields showing a response other than missing or unknown in the MIS.	All madatory fields completed in the MIS for all SSP Registered Clients at the time of enrollment.	100%	MIS Reports	
Percentage of Mandatory Program Services (MPS) SSP Service units delivered.	95% of MPS SSP service units delivered.	100%	MIS Reports	
YTD unduplicated SSP Registered Clients that have ADL and IADL fields populated with responses other than missing or unknown.	95% of Registered SSP Clients have ADL and IADL FILEDS completed in the MIS. ADLS: eating, bathing, toileting, transferring, walking, and dressing. IADLs: meal preparation, shopping, medication, management, using telephone, heavy housework, light housework, transportation.			
Specific Tasks	**Standards**	**Acceptable Quality Level**	**Data Source**	**Remedies for Non-Compliance**
Intake, Assessments, Care Plan (Ref. SOW Sec. 10 Specific Work Requirements)	Intake using the Universal Intake Form (UIF) to determine eligibility and identify Services, and comprehensive Assessments (include all Case Management forms) on 100% of Clients that received SSP Registered Services to be completed within fourteen (14) days of initial contact.	100%	Client File & MIS reports	If Contractor performance does not meet the Acceptable Quality Level, the County Will have the opt1on to apply the following remedies 1) Corrective Action Plan, 2) Suspension of Payment; 3) Suspension of Contract, 4) Reduce and reallocate funds; and 5) Term1natlon of Contract.
Service Provision (Ref. SOW Sec. 10.9)	Ensure that SSP Clients begin receiving Services within 14 (fourteen) days of completing the Client intake process.	95%	Client File & MIS reports	
	Ensure that all SSP Clients' Care Plan achieved successful measurable outcomes within the established timeline of service in order to accomplish the Program's intent for each Client. The Care Plan serves as an agreement between Client and Care Manager, addresses the Client's needs and problems presented, and incorporates the goals and services/intervention that are needed to enhance the current support system.	80%		
Reassessment (Ref. SOW Sec. 10.9.1.4)	Conduct a face-to-face Reassessment every 6 (six) months for 100% of Clients that receive ongoing SSP registered Services.	95%	Client File & MIS reports	
Case Management Active Client Caseload (Ref. SOW Sec. 6.3.9.2)	Each full-time Case Manager shall be assigned no more than fifty (50) active Clients at a time (client caseload ration is 50:1) Example: For a minimum caseload of 100 clients, two full-time equivalent (FTE) professionals must be on staff. A caseload range of +/- 10 percent based on the 50:1 ratio is allowed. However, the client caseload shall not fall below 90% minimum of clients set by County.	95%	Client File, MIS reports, & Personnel/Budget Reports	If Contractor performance does not meet the Acceptable Quality Level, the County Will have the opt1on to apply the following remedies 1) Corrective Action Plan, 2) Suspension of Payment; 3) Suspension of Contract, 4) Reduce and reallocate funds; and 5) Term1natlon of Contract.

ATTACHMENT 2

SUBAWARD DISCREPANCY REPORT

TO:

FROM:

DATES: **Prepared:** _____
Returned by Subrecipient:_____
Action Completed: _____

DISCREPANCY PROBLEMS: _____
_____
_____
_____

_____ _____
Signature of County Representative Date

CONTRACTOR RESPONSE (Cause and Corrective Action):_____
_____
_____
_____

_____ _____
Signature of Subrecipient Representative Date

COUNTY EVALUATION OF SUBRECIPIENT RESPONSE:_____
_____
_____
_____

_____ _____
Signature of Subrecipient Representative Date

COUNTY ACTIONS:_____
_____
_____
_____

SUBRECIPIENT NOTIFIED OF ACTION:
County Representative's Signature and Date

_____
Subrecipient Representative's Signature and Date

_____

Agency Name: _____ Client Name: _____Date: _____

UNIVERSAL INTAKE FORM

Funding Identifier:

Title IIIB ☐ Title C1 ☐ Title C2 ☐ Title IIIE ☐ Title IIIE(G) ☐ Linkages ☐

IDENTIFICATION

1a	Applicant Last Name	First Name	Middle Initial	GetCare ID #

Date of Birth (D.O.B.)	Age	Social Security # (*Optional*)	
Home Address *(Number/Street)*	City	State	Zip Code
Mailing Address *(If different than home address)*	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Email Address			

DEMOGRAPHICS

1b

Rural Designation
☐ Rural ☐ Urban ☐ Declined to State

Unincorporated City
☐ Yes ☐ No ☐ Declined to State

Sex at birth
☐ Male ☐ Female ☐ Declined to State

Gender
☐ Male ☐ Female ☐ Transgender Female to Male
☐ Transgender Male to Female ☐ Genderqueer/ Gender
☐ Non-binary ☐ Not Listed ☐ Declined to State

Sexual Orientation
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same Gender-Loving ☐ Questioning/Unsure
☐ Not Listed ☐ Declined to State

Veteran ☐ Yes ☐ No ☐ Declined to State

Spouse of Veteran ☐ Yes ☐ No ☐ Declined to State

Race
☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese
☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian
☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Multiple Race ☐ Declined to State

Ethnicity
☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Relationship Status ☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced
☐ Widowed ☐ Declined to State

Agency Name: _____ Client Name: _____Date: _____

1b Cont.

Type of Residence

☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home

☐ Nursing Home ☐ Residential Care Home

☐ Room and Board ☐ Homeless ☐ Other ☐ Declined to State

Does the individual

☐ Rent ☐ Own ☐ Other

☐ Declined to State

Employment Status

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State

Living Arrangement

☐ Lives alone without help ☐ Lives with others without help

☐ Lives alone with help 4 hrs/day or less

☐ Lives with others with help ☐ Declined to State

Federal Poverty Guideline (FPG)

Is your income ☐ At or below 100% FPG

☐ Above 100% FPG

☐ Declined to State

Primary Language

☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English

☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog

☐ Thai ☐ Vietnamese ☐ Other ☐ Declined to State

Translation needed ☐ Yes ☐ No ☐ Declined to State

EMERGENCY CONTACTS

2

Contact Last Name	First Name		Middle Initial
Address *(Number/Street)*	City	State	Zip Code
Home Phone / Work Phone	Cell Phone	Relationship	
Contact Name (*Last, First, Middle Initial*) – *Optional*			
Address *(Number/Street)*	City	State	Zip Code
Home Phone / Work Phone	Cell Phone	Relationship	
Primary Physician		Office Phone	
Physician's Address	City	State	Zip Code

Agency Name: _____ Client Name: _____Date: _____

BENEFITS

3	Are you currently receiving Social Security Benefits? ☐ Yes ☐ No ☐ Declined to State	Do you currently receive Supplemental Security Income (SSI) Benefits? ☐ Yes ☐ No ☐ Declined to State

Do you participate in CalFresh (Food Stamps, SNAP, EBT)? ☐ Yes ☐ No ☐ Declined to State

Do you have Health Insurance? ☐ Yes ☐No ☐ Declined to State	Health Insurer's Name	Policy Number: *(Optional)*
Do you receive Medi-Cal? ☐ Yes ☐ No ☐ Declined to State	Medi-Cal # *(Optional)* Issue date:	Do you receive Medicare? ☐ Yes ☐ No ☐ Declined to State

Do you receive In-Home Supportive Services *(IHSS)?* ☐ Yes ☐ No ☐ Declined to State

Do you receive any additional benefits? (i.e., Veterans Benefits, CAPI, etc.)

REFERRAL INFORMATION

4 Referral Source

Last Name	First Name	Phone	
Address	City	State	Zip Code

Presenting Problems/Services Requested/Comments/Follow-up:

NUTRITIONAL RISK FACTORS

5 **NUTRITIONAL RISK FACTORS**
(Add the numbers from each checked box to determine Nutrition Risk Score)

I have an illness or condition that made me change the kind and/or amount of food I eat.	2 □ Yes	□ No	□ Declined to State
I eat fewer than 2 meals per day.	3 □ Yes	□ No	□ Declined to State
I eat few fruits or vegetables or milk products.	2 □ Yes	□ No	□ Declined to State
I have 3 or more drinks of beer, liquor or wine almost every day.	2 □ Yes	□ No	□ Declined to State
I have tooth or mouth problems that make it hard for me to eat.	2 □ Yes	□ No	□ Declined to State
I don't always have enough money to buy the food I need.	4 □ Yes	□ No	□ Declined to State
I eat alone most of the time.	1 □ Yes	□ No	□ Declined to State
I take 3 or more different prescribed or over-the-counter drugs a day.	1 □ Yes	□ No	□ Declined to State
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 □ Yes	□ No	□ Declined to State
I am not always physically able to shop, cook and/or feed myself.	2 □ Yes	□ No	□ Declined to State
Total Nutritional Risk Score		(If total is 6 or more, participant is at **High** Nutritional Risk)	

Agency Name: _____ Client Name: _____Date: _____

ADL/IADL RISK FACTORS & DISABILITY FACTORS

6 ACTIVITIES OF DAILY LIVING (ADL)/INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS *(Excluding Title IIIE Caregiver Program)*

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Med. Mgmt.	☐	☐	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Hvy. Housework	☐	☐	☐	☐	☐	☐
Lt. Housework	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐

Disability Factors

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired

☐ Physically Impaired ☐ Walking Aid ☐ Wheelchair

☐ Bedbound ☐ Memory Impaired ☐ Depression

☐ Cognitively Impaired ☐ None ☐ Declined to State

Recent Hospital Discharge ☐Yes ☐ No

☐ Declined to State

Date of Discharge

Date To Stop Service

Hospital

Diabetic

☐ Yes ☐ No

☐ Declined to State

Have you been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No ☐ Declined to State

Agency Name: _____ Client Name: _____Date: _____

TITLE IIIE CARE RECEIVER DEMOGRAPHICS

7 TITLE IIIE CARE RECEIVER DEMOGRAPHICS

Please make additional copies of Section 7 & 8 if more than one Care Receiver

Caregiver Relationship: ☐ Spouse ☐ Domestic Partner ☐ Sibling ☐ Son/Son-in-Law ☐ Daughter/Daughter-in-Law ☐ Grandparent ☐Other Relative ☐ Non-Relative ☐Other ☐ Declined to State

Care Receiver Last Name	First Name	Middle Initial	Care Receiver GetCare ID #

Address (Number & Street)	City	State	Zip Code

Rural Designation	Unincorporated City
☐ Rural ☐ Urban ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Home Phone	Work Phone	Cell Phone	Emergency Contact Phone

Date of Birth (D.O.B.)	Age	Gender ☐ Male ☐ Female ☐ Declined to State

Social Security # (Optional)	Email Address

Veteran	Spouse of Veteran
☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Race

☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese

☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian

☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Multiple Race ☐ Declined to State

Ethnicity

☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Relationship Status

☐ Single *(Never Married)* ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

☐ Declined to State

Type of Residence	Does the individual	Living Arrangement
☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home ☐ Nursing Home ☐ Residential Care Home ☐ Room and Board ☐ Homeless ☐ Other ☐ Declined to State	☐ Rent ☐ Own ☐ Other ☐ Declined to State	☐ Alone ☐ Not Alone ☐ Declined to State

Receive In-Home Supportive Services *(IHSS)?*	Federal Poverty Guideline (FPG) Is your Care Receiver income
☐ Yes ☐ No ☐ Declined to State	☐ At or below 100% FPG ☐ Above 100% FPG ☐ Declined to State

Have Health Insurance?	Receive Medicare?	Receive Social Security?	Receive Medi-Cal?
☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State	☐ Yes ☐ No ☐ Declined to State

Agency Name: _____Client Name: _____Date: _____

TITLE IIIE CARE RECEIVER ADL/IADL RISK FACTORS & DISABILITY FACTORS

8 TITLE IIIE CARE RECEIVER ACTIVITIES OF DAILY LIVING (ADL)/ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS

Activities of Daily Living *(ADL) (Grandchildren exempt)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	□	□	□	□	□	□
Bathing	□	□	□	□	□	□
Toileting	□	□	□	□	□	□
Transferring	□	□	□	□	□	□
Walking	□	□	□	□	□	□
Dressing	□	□	□	□	□	□

Instrumental Activities of Daily Living *(IADL) (Grandchildren exempt)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	□	□	□	□	□	□
Shopping	□	□	□	□	□	□
Med. Mgmt.	□	□	□	□	□	□
Money Mgmt.	□	□	□	□	□	□
Using Phone	□	□	□	□	□	□
Hvy. Housework	□	□	□	□	□	□
Lt. Housework	□	□	□	□	□	□
Transportation	□	□	□	□	□	□

Disability Factors

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired ☐ Physically Impaired ☐ Walking Aid

☐ Wheelchair ☐ Bedbound ☐ Memory Impaired ☐ Depression ☐ Cognitively Impaired ☐ None

☐ Declined to State

Diabetic

☐Yes ☐ No

☐ Declined to State

Has Care Receiver been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No ☐ Declined to State

Agency Name: _____ Client Name: _____Date: _____

CERTIFICATION

9

CERTIFICATION

(To be completed by Interviewer and signed by Client)

I certify that the information on this form, provided to me by the client, is accurate and true to the best of my abilities. I also certify that I have informed the Client that this information may be shared with other providers for the purpose of providing services. Client signature establishes agreement to services.

Completed by (Print Name)	*Phone*
Signature	*Date*
Client Name (Print)	
Client Signature	*Date*

DISENROLLMENT

10 **REASON FOR DISENROLLMENT** *Date of disenrollment:*

☐ Deceased ☐ Moved Out of Service Area ☐ No Longer Desires Services ☐ No Longer SNF Certifiable

☐ No Longer Medi-Cal Eligible ☐ Institutionalization ☐ High Cost of Services ☐ Won't Follow Care Plan

☐ On Hold ☐ Service No Longer Needed ☐ Past Active ☐ On Waiting List ☐ Other Reason

NOTES:

Thank you for completing the Universal Intake Form (UIF). As the aging population grows and funding remains limited, it is vital to capture this critical information to reinforce and substantiate the increased demand for older adult services. This information will assist the Los Angeles County Area Agency on Aging (AAA) in identifying unmet needs, effectively developing plans, and better coordinate services to meet your needs.

ATTACHMENT 4
(COUNTY RECOGNIZED HOLIDAYS)

New Year's Day.....January 1

Martin Luther King Jr.'s Birthday .....The third Monday in January

Presidents' Day ..... The third Monday in February

Cesar Chavez Day…….....The last Monday in March

Memorial Day ..... The last Monday in May

Independence Day .....July 4

Labor Day..... The first Monday in September

Indigenous Peoples Day ..... The second Monday in October

Veteran's Day.....November 11

Thanksgiving Day.....The fourth Thursday in November

Friday after Thanksgiving .....The fourth Friday in November

Christmas .....December 25

*If January 1st, July 4th, November 11th or December 25th fall on a Saturday, the preceding Friday is a holiday.

*If January 1st, July 4th, November 11th or December 25th fall on a Sunday, the following Monday is a holiday.

(Los Angeles County Code Ordinance 96-0003 Section 2, 1996)

County of Los Angeles - Community and Senior Services
Area Agency on Aging
Family Caregiver Support Program Non-Registered Services
FY 2016-17 Q1

Attachment 5
Example: Quarterly Information Services Reporting Form

Service Provider Name: _____

Community Education

Designed to education groups of current or potential caregivers about available FCSP and other Caregiver support resources and services. One (1) community education activity equals two (2) hours of education provided to a minimum of ten (10) participants.

Caregivers Serving Elderly

Month	Activity Name (i.e. Conference Presentation) and Brief Description (i.e. conducted presentation on caregiver self-care)	Activity Date(s)	Location(s)	Unduplicated Clients Served
Jul-16				
Aug-16				
Sep-16				
			Total	0

Public Information

Designed to provide information about available FCSP and other caregiver support resources and services by disseminating publications such as newsletter, brochures, and flyers. One (1) public information activity equals providing inforamtion and/or resources for a minimum of two (2) consecutive hours.

Caregivers Serving Elderly

Month	Activity Name (i.e. Community Resource Fair) and Brief Description (i.e. provided informational print materials)	Activity Date(s)	Location(s)	Unduplicated Clients Served
Jul-16			Phone	
Aug-16				
Sep-16				
			Total	0

Please make sure that these are estimated unduplicated client counts; for CDA reporting purposes, we are only allowed to report a client once during the Fiscal Year.

Please insert additional dates if needed.

ATTACHMENT 6
(EMERGENCY AND DISASTER PLAN BASIC REQUIREMENTS)

A. Emergency and Disaster Plan Mission and Introductory Statement

The mission and introductory statement could be the local Office of Emergency Services (OES) statement, or an expansion of it. The mission and introductory statement should include the following elements:

- How the agency will maintain the continuity of agency services to program recipients during and following disaster and emergency events.
- How the agency will advocate on behalf of older individuals, and their family caregivers within their PSA, to assure that the special needs of older individuals are adequately met, during and following the event.

The agency's mission and introductory statement might also include how the agency will:

- Assist older individuals and their family caregivers, who may have additional needs resulting from a disaster or an emergency event.
- Provide information and assistance to stakeholders on how to be prepared to meet their own needs during and following the event.
- Focus on resuming services as quickly as possible following the event.
- Collaborate with local disaster preparedness partners to coordinate services for older individuals and their family caregivers within their PSA.
- Prepare for a change in both service demands and in the individual needs of clients currently being served by the agency's network.

B. Business Continuity Plan

Develop a Business Continuity Plan (BCP) for your agency to ensure that your mission can be carried out. The BCP should:

- Provide a brief statement describing the plan for service-continuity following a disaster if normal resources are unavailable or demand exceeds capacity.
- List any MOU or vendor agreements that are in place to provide emergency back-up for operations or key resources.

Have a copy of each signed agreement in an appendix to the plan and on a data-storage device, and review and revise the agreements on an annual basis to assure they remain current.

- Include a contingency plan for staff that are absent or unable to complete their assigned duties.
- Include a system to track emergency expenditures, since they may be reimbursable
- Emphasize communications, backup systems for data, emergency service delivery options, community resources, and transportation.

C. Emergency Response Organization Chart

The chart should include the name, title, and contact information of staff involved in disaster and emergency related activities. Outline the relationships and responsibilities for each person responsible for each function:

- Management – who will take charge, delegate responsibilities, and provide overall direction?

- Operations – who will perform the actions required to get people to safety, restore services, and meet needs or help with recovery?
- Planning – who will gather information and communicate assessments about the emergency and related needs?
- Logistics – who will obtain resources that operations may require?
- Finance – who will track expenditures, hours worked, and document events as they occur?

D. Roster of Critical Local Contacts in an Emergency

Include a roster of all contact/agency resources for your Planning and Service Area. The roster should include at least the following:

- Local OES contact information for each county/city within the PSA.
- First responders and law enforcement agencies (Fire, Police, Sheriff).
- Hospitals in the service area.
- American Red Cross and other private relief organizations.
- Community disaster preparedness groups, such as Volunteer Organizations Active in Disasters (VOAD).
- Telephone or communication tree, individuals on the Agency's Disaster Preparedness Organizational Chart, and order of contact priority.
- Media – local news/emergency broadcast radio and television stations.
- Any additional contacts as appropriate for your community (Ministerial Alliance/Council of Churches).
- Citizen-band clubs or HAM radio operators.

Roster of Critical Local Contacts in an Emergency (Sample)

Agency Name:_____ County/City:_____ Roster Date:_____

Agency	Contact Name/Title	Contact Telephone Numbers	Contact Email Address
Example: Local Office of Emergency Services	Joe Cool, Director of Special Needs Population	Work: Cell: Fax: Home:	jcool@county.gov

E. Communication Plan

The communication plan should include at least the following: first responders, agency staff, service providers, community partners, media, volunteers, clients, local Office of Emergency Services, and the AAA Emergency Coordinator.

Communication Plan (Sample)
(Earthquake scenario used as an example – other scenarios can be substituted)

Who	How	What	When	Where	Why
Who needs to know	*How will the message be communicated*	*What message do you want to convey to them*	*When do they need to know or what is the date/time for the information*	*Where are the areas affected, providers affected, geographic area, locations of services*	*Why do they need this information*
Service Providers	*Telephone, email, cellular phone*	*Location of elderly and disabled shelter locations*	*Dates shelters are expected to be in operation*	*Address and contact information for shelters*	*Regular shelters are not available for special needs victims*

ATTACHMENT 7

Site Emergency Resource Survey

Organization Name: _____

Organization Address: _____

Organization Emergency Coordinator Name: _____

Organization Emergency Coordinator Phone Number: _____

After Hours or Cell Phone Number: _____

Organization Emergency Coordinator Email Address: _____

1. Given the need to shelter people (especially older individuals and individuals with disabilities) in the community following a major disaster, could your facility provide temporary shelter space for one or two days?

   ____Yes ___No ___Maybe (w/ training & support)

   If different from the address listed above, please attach the address of each facility to this survey.

2. If you answered "Yes," to question number 1, how many people can you accommodate? (Please check your best estimate)

   ___ 1 to 25 ___26 to 50 ___ 51 to 75

   ___76 to100 ___101 or more (please specify:_____)

3. In an emergency or disaster, what resources (or supplemental services) could your organization provide? Check all that apply.

_____ Counseling Services	_____ Emergency Power/Generator
_____ Temporary Housing	_____ Emergency First Aid
_____ Home/Neighborhood Cleanup	_____ Volunteers
_____ Site for Food/Water	_____ Kitchen/Cooking Facilities
_____ Storage Distribution	_____ Other (please indicate below):

4. Following a major emergency or disaster, could your facility assist in transporting older individuals and individuals with disabilities to disaster services?

____ Yes (assuming the resources are not in use) ___ No

If you responded "Yes", what transportation resources does your organization have? Check all that apply.

___ Passenger Sedan(s) ___ Vans (Passenger or Cargo)
___ Trucks (Including Pickups) ___ Vans with Wheelchair Lifts
___ Other (please indicate below):

5. Please indicate the support that your organization could provide with language translation, including sign language, at disaster service centers. List languages (other than English):

6. Given the community that your organization serves, would you be able to help in assessing the needs of older individuals in that community or neighborhood following an emergency or disaster?

___ Yes ___ No ___ Maybe (depending on resources at the time)

Please indicate the names of the areas, neighborhoods, or communities where you would be able to assess the needs of older individuals?

For organizations that provide meal services:

1. Please indicate the type of meal services that your organization provides. Check all that apply.

   ____ Congregate Meals ____ Home-delivered Meals ____ Emergency Meals

2. Given your resources, could your organization expand meal services following an emergency or disaster to meet the needs in the community?

   ____ Yes ___ No

   If yes, provide the following information for each site that will be able to have expanded meal services:

   Site Name: _____

   Site Address:_____

   Site Number: _____

   Site Emergency Coordinator Name: _____

   Site Emergency Coordinator After Hours or Cell Phone Number: _____

   Site Emergency Coordinator E-mail: _____

After completing this survey, please send an electronic copy to Michael Gavigan at MGavigan@wdacs.lacounty.gov

**It is the responsibility of the AAA Contractor and Title V Host Agency to contact the AAA Emergency Coordinator or designee if there are any changes to information provided on the survey. An updated and completed survey must be provided.*

ATTACHMENT 8
COMMUNITY FOCAL POINTS LIST
CCR Title 22, Article 3, Section 7302(a)(14), 45 CFR Section 1321.53(c), OAA 2006 306(a)

In the form below, provide the current list of designated community focal points and their addresses. This information must match the total number of focal points reported in the National Aging Program Information System (NAPIS) State Program Report (SPR), i.e., California Aging Reporting System, NAPISCare, Section III.D.

Designated Community Focal Point	Address
Alhambra, City of: Joslyn Adult Center	210 North Chapel Avenue Alhambra, CA 91801
Altadena Community Center (CSS)	730 East Altadena Drive Altadena, CA 91001
Altadena Senior Center (CSS)	560 East Mariposa Street Altadena, CA 91001
Altamed Health Service: California Southland Chapter	Site 1: 512 South Indiana Street Los Angeles, CA 90063 Site 2: 4421 Wilshire Boulevard Suite #400 Los Angeles, CA 90010
Armenian Relief Society	518 West Glenoaks Boulevard Glendale, CA 91202
Antelope Valley Senior Center (CSS)	777 West Jackman Street Lancaster, CA 93534
Asian Senior Center (CSS)	14112 South Kingsley Drive Gardena, CA 90249
Avalon Medical Development Corp: Catalina Island Medical Center	100 Falls Canyon Road Avalon, CA 90704
Azusa, City of: Azusa Senior Center /Azusa Recreation & Family Service	Site 1: 740 North Dalton Avenue Azusa, CA 91702 Site 2: 320 North Orange Place Azusa, CA 91702
Bet Tzedek Justice for All	3250 Wilshire Boulevard 13th Floor Los Angeles, CA 90010
Burbank, City of : Joslyn Adult Center /Tuttle Center	Site 1: 1301 West Olive Avenue Burbank, CA 91506 Site 2: 1731 North Ontario Burbank, CA 91505

Centro Maravilla Service Center (CSS)	4716 East Cesar East Chavez Avenue Los Angeles, CA 90022
Cerritos Senior Center	12340 South Street Cerritos, CA 90703
Chinatown Service Center: Little Tokyo Service Center /Korean Health Education, Info. & Research Center	Site 1: 231 East 3rd Street Suite # G106 Los Angeles, CA 90013 Site 2: 3727 West 6th Street Suite #230 Los Angeles, CA 90020 Site 3: 320 South Garfield Avenue Suite#202 Alhambra, CA 91801
Claremont, City of: Joslyn Center /Blaisdell Community Center	Site 1: 660 North Mountain Avenue Claremont, CA 91711 Site 2: 440 South College Avenue Claremont, CA 91711
Culver, City of: Culver City Senior Center / Roxbury Park Community Center	Site 1: 4095 Overland Avenue Culver City, CA 90232 Site 2: 471 South Roxbury Drive Beverly Hills, CA 90212
East Los Angeles Senior Center (CSS)	133 North Sunol Drive Suite# 237 Los Angeles, CA 90063
East Rancho Dominquez Service Center (CSS)	4513 East Compton Boulevard Compton, CA 90221
El Monte, City of: Jack Crippen Multipurpose Senior Center	3120 North Tyler Avenue El Monte, CA 91731
Florence/Firestone Service Center (CSS)	7807 South Compton Avenue Los Angeles, CA 90001
Gardena, City of	1670 West 162th Street Gardena, CA 90247
Glendale, City of : Adult Recreation Center / Sparr Heights Community Center	Site 1: 201 East Colorado Glendale, CA 91205 Site 2: 1613 Glencoe Way, Glendale, CA 91208

Grandparents As Parents, Inc. : Corporate Office / Edelman Court Caregiver Center	Site 1: 22048 Sherman Way #217 Canoga Park, CA 01303 Site 2: 201 Center Plaza Drive – 5th Floor #422 Monterey Park, CA 91754
Human Services Association	6800 Florence Avenue Bell Gardens, CA 90201
Jewish Family Service: West Hollywood Comprehensive Service Center /Freda Mohr Multipurpose Center	Site 1: 7377 Santa Monica Boulevard West Hollywood, CA 90046 Site 2: 330 North Fairfax Avenue Los Angeles, CA 90036
Just Rite Community Program	17715 Chatsworth Street, Suite 210 Granada Hills, CA 91344
Long Beach Senior Center	1150 East 4th Street Long Beach, CA 90802
Los Nietos Senior Center (CSS)	11640 East Slauson Avenue Whittier, CA 90606
Norwalk, City of : Senior Center	14040 San Antonio Drive Norwalk, CA 90650
Office of Samoan Affairs	20715 South Avalon Boulevard Suite# 200 Carson, CA 90746
Oldtimers Foundation	3355 East Gage Avenue Huntington Park, CA 90255
Pomona, City of: Community Service Department	499 East Arrow Hwy Pomona, CA 91767
Potrero Heights Park Community and Senior Center (CSS)	8051 Arroyo Drive Montebello, CA 90640
San Fernando, City of: Las Palmas Park	505 South Huntington Street San Fernando, CA 91340
San Gabriel Valley Service Center (CSS)	1441 Santa Anita Avenue South El Monte, CA 91733
San Gabriel Valley YWCA	943 North Grand Avenue Covina, CA 91724
San Pedro Service Center (CSS)	769 West Third Street San Pedro, CA 90731

Santa Anita Family Service	605 South Myrtle Avenue Morovia, CA 91016
Santa Clarita Valley Community on Aging	22900 Market Street Santa Clarita, CA 91321
Santa Clarita Valley Service Center (CSS)	24271 Main Street Newhall, CA 91321
Senior Care Action Network (SCAN)	2501 Cherry Avenue Suite# 380 Signal Hill, CA 90755
South El Monte, City of : Senior Center	1556 Central Avenue South El Monte, CA 91733
Southeast Area Social Service Funding Authority	10400 Pioneer Boulevard Suite # 9 Santa Fe Springs, CA 90670
Special Services for Groups: Older Adult Division	1730 West Olympic Boulevard Floor 3A Suite 100 Los Angeles, CA 90015
Torrance, City of: Community Services Department, Bartlett Senior Center	1339 Post Avenue. Torrance, CA 90501
Torrance South Bay Family YMCA	2900 West Sepulveda Boulevard Torrance, CA 90505
USC/LA Caregiver Resource Center	3715 McClintock Avenue Los Angeles, CA 90089
Watts Labor Community Action Committee: Bradley Multipurpose Center	10937 South Central Avenue Los Angeles, CA 90059
West Covina, City of	1444 West Garvey Avenue West Covina, CA 91793
Wise & Healthy Aging	1527 4th Street, 2nd Floor Santa Monica, CA 90401
Willowbrook Senior Center (CSS)	12915 South Jarvis Avenue Los Angeles, CA 90401

III B- Supportive Services Program (SSP) Program
CARE MANAGEMENT APPLICATION AND INFORMED CONSENT

Site: _____

Applicant's Name: _____

Address: _____

_____ Telephone No.: _____

Medi-Cal No.: _____ Client I.D. # _____

I HEREBY APPLY TO PARTICIPATE IN THE SUPPORT SERVICES PROGRAM (SSP) CARE MANAGEMENT, SUBJECT TO DETERMINATION OF ELIGIBILITY.

I UNDERSTAND THAT SUPPORT SERVICES PROGRAM CARE MANAGEMENT WILL CONSIST OF:

- An assessment of my health and social needs. The purpose of the assessment will be to determine if I am eligible to participate in the Program and to provide the SSP Care Manager with enough information about my needs to develop a plan of services to help me remain in the community; and

- A care plan, developed by the SSP Care Manager with my approval, which addresses health and social services needs to help me remain in the community; and

- A Care Manager who will be assigned to me to be my ongoing contact for as long as I participate in the Program.

I UNDERSTAND THAT:

- I am not required to participate in the assessment. If I choose not to participate, I will not be eligible for care management from SSP.

- If I choose not to participate, it will not have any effect on current and future services and benefits I receive and that information and referral can be provided to me without an assessment.

- If I choose to participate, I will be involved in deciding what services I require and in any changes in the plan for services.

- Information about me will be confidential and will be used only by staff of SSP and the Linkages, service providers who will be serving me, and specific persons to

whom I have released the information, in accordance with the State Linkages Program policy.

- I will not be individually identified in any reports about this program.

I UNDERSTAND THAT IF I AM FOUND ELIGIBLE I WILL BE GIVEN AN OPPORTUNITY TO DETERMINE MY ABILITY TO CONTRIBUTE TO THE COST OF THE SERVICES PROVIDED TO ME BY THE SUPPORT SERVICES PROGRAM. NO SHARE OF COST WILL BE REQUESTED WITHOUT MY PRIOR DETERMINATION OF THE AMOUNT I AM ABLE TO PAY.

_____

Signature (applicant or responsible other)

I HAVE EXPLAINED THE PURPOSE OF CASE MANAGEMENT AND THE NATURE OF THE INVOLVEMENT OF THE PARTICIPANT. I HAVE ANSWERED ALL QUESTIONS ABOUT THE ASSESSMENT ASKED BY THIS CLIENT AND/OR BY RESPONSIBLE CONCERNED PERSONS ASKING ON BEHALF OF THIS PARTICIPANT.

_____

Care Manager Signature (Date)

Date copy provided to client: _____

III B- Supportive Services Program (SSP) Program
AUTHORIZATION TO RELEASE RECORDS

STATE LAW REQUIRES YOUR SPECIFIC AUTHORIZATION FOR US TO OBTAIN OR RELEASE TO APPROPRIATE PARTIES ANY INFORMATION ABOUT YOUR TREATMENT FOR CERTAIN CONDITIONS. PLEASE READ AND CHECK ALL PERTINENT SECTIONS BELOW.

I authorize _____
(Individual or Agency)

to disclose to _____
(Individual or Agency to Receive Information)

records relating to my (my_____'s) diagnosis and/or treatment for:

(check all pertinent items)

( ) Physical injuries, illnesses or conditions
( ) Mental (psychological or psychiatric) illnesses or conditions
( ) Alcohol abuse and/or drug abuse
( ) Cash assistance, Medi-Cal benefits or other social and health services received

This information is required for:

_____

_____

and is to be limited to:

_____

_____

I may revoke this authorization at any time before the information has been released. In any case, the authorization automatically expires two years from the date of this authorization.

_____
(Date)

YOU MAY RETAIN A COPY OF THIS AUTHORIZATION. Initial here if you desire a copy.

_____
The following information is needed to assure accurate identification.

Client (Print name)

Place of Birth

Client Signature/Authorized Representative

Date of Birth

Date of Authorization

III B- Supportive Services Program (SSP) Program
Assessment General Information

Client Name:	ID No.:

Enrollment Date:		Reason for Disenrollment:
Assessment Date:		
Reassessment Date:		
Disenrolled Date:		

Educational Level:

☐ No School Completed	☐ 10th Grade	☐ Bachelor's Degree
☐ 1st through 4th Grade	☐ 11th Grade	☐ Master's Degree
☐ 5th through 8th Grade	☐ 12th Grade - No Diploma	☐ Some College - No Degree
☐ 9th Grade	☐ High School Grad.	☐ Associate Degree
☐ Other:		

Income:

Monthly Household Income(use DHHS Poverty Level): _____

DHSS Family Level:_____

Household monthly expenses: _____

Details of expenses:

Mortgage/Rent: _____ Utility Bills: _____ Food: _____

Medications: _____ Healthcare: _____ Other: _____

Housing:

Client lives in an owned house with 0 individuals. ☐Yes ☐No

Is client living in a HUD facility? ☐Yes ☐No	HUD Payment:$	Client Payment:$
If not HUD, indicate monthly rent/mortgage payment:$		
Does client participate in any Utilities Programs to lower cost of their monthly bill? ☐Yes ☐No	If so, which ones?	
Evidence or indication of abuse, neglect, or exploitation ☐Yes ☐No		

Client Name:	ID No.:	Date:

General Health

Physician and Other Health Professionals:

NAME	SPECIALTY	ADDRESS	PHONE NO.

Client's Major Health Problems/Diagnosis:

Has Client Fallen in the Last Six Months? ☐ Yes ☐ No If Yes, Frequency of falls: _____

Assistive Devices Used by Client? _____

Has Client been in a Nursing Facility in the Past Six (6) months? ☐ Yes ☐ No

If Yes, please describe: _____

How many times has client been hospitalized in the last 12 months? _____

Does Client require a Special Diet? ☐ Yes ☐ No If Yes, type of diet:

_____

Does Client have high Nutritional Risk score of 6 or above as specified in the Universal Intake Form (UIF): ☐ Yes ☐ No If Yes, refer client to Nutrition Counseling service provided by Consulting Nutritional Services (CNS) Registered Dietitian.

Formal/Informal Support:

Does the Client have formal support? ☐ Yes ☐ No	If Yes, by whom?
If yes, Number of Hours per month:	
Formal Support Effectiveness:	
Does the Client have informal support including family caregiver? ☐ Yes ☐ No	If Yes, by whom?
Does the family caregiver need assistance in Caregiving Services? ☐ Yes ☐ No	If yes, refer client to the Family Caregiver Support Service Provider:
Informal Support Effectiveness:	
Comments:	

Client Name:	ID No.:	Date:

Medications List (Including non-prescription medications and vitamins/minerals):

	Date	Medication	Reported Purpose	Dosage	#Freq. RX	Doctor	Covered by Medi-Cal Yes/No
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

Does the Client know why they are taking these medications? ☐ Yes ☐ No

If NO, Case Manager Intervention:

_____

General concerns regarding medications: ☐ Yes ☐ No

(Optional) Sent for Review to Doctor(s): _____Date:_____

Client Name:	ID No.:	Date:

Areas of Concern:

Does the client have problems in any of the following areas that prevent doing activities? Indicated with an "X" if a condition applies or not, and explain:

	Yes	No	Explanation (If Necessary)
Vision			
Hearing			
Speech			
Dental			
Swallowing			
Elimination			
Feet			
Short of Breath			
Pain			
Paralysis			
Amputation			
Recent Infection			
Allergies			
Substance Abuse			
Mental Illness			

Environmental Safety:

Must the client climb stairs to enter or leave the house? ☐Yes ☐No

If Yes, is it a problem?

Check any of the following that are problems:

☐ Loose Rugs	☐ Inadequate Kitchen Facilities
☐ Electrical Cords	☐ Inadequate Bathroom Facilities
☐ Cluttered House	☐ Inadequate Cooling
☐ Unclean House	☐ Inadequate Heating
☐ Phone Accessibility	☐ Other:

Equipment Needs:

	Has	Needs	N/A		Has	Needs	N/A
Tub	☐	☐	☐	Raised Commode	☐	☐	☐
Shower	☐	☐	☐	Grab Bar/Toilet	☐	☐	☐
Handheld Shower	☐	☐	☐	Grab Bar/Shower	☐	☐	☐
Bath-bench/Chair	☐	☐	☐	Smoke Alarm	☐	☐	☐
Emergency Alarm Unit	☐	☐	☐	Bedside Commode	☐	☐	☐
Incontinence Supplies	☐	☐	☐	Other:			

Client Name:	ID No.:	Date:

PSYCHOLOGICAL FUNCTIONING:

	Evidence of problem (check one)			Comments/Describe
	NONE	SOME	SEVERE	
Anxiety				
Combative, Abusive,				
Hostile Behavior				
Depression				
Delusions/Hallucinations				
Wandering				
Paranoid Thinking/				
Suspiciousness				
Suicidal				
Dementia				
Other (i.e., Grief/Substance Abuse)				

Adaptive Coping Skills:

Has Client Experienced Any Significant Events or Changes in the Last year?

Any Problems Related to Client's Living Arrangement?

ATTACHMENT 9

III B- Supportive Services Program (SSP) Program
ASSESSMENT SUMMARY

These are general guidelines: include only information that is pertinent to develop and support a care plan. Focus on changes. It is not necessary to include information in more than one section of the summary - place it where it has most relevance.

Client Name: _____ ID No.:_____ Date:_____

1. Client Description: *(Age, living arrangement, physical appearance and presentation)*

2. Health: *(Diagnosis; changes in general health status, health practices, medical compliance, nutrition, continence, problematic signs or symptoms, frequency and adequacy of health care)*

3. Medications: *(Medication use/interactions, ability to self manage)*

4. ADL/IADL Functioning Levels: *(Changes in ambulatory status, functional abilities, assistive devices, areas of unmet need; support for LOC finding)*

5. Caregiver: *(Formal and informal support, reliability and skill level of caregiver, degree of caregiver stress, evidence of caregiver health or financial problems)*

6. Environmental Safety: *(Adequacy of home; safety and accessibility consideration*

ATTACHMENT 9

III B- Supportive Services Program (SSP) Program
ASSESSMENT SUMMARY

Client Name: _____ ID No.:_____ Date:_____

7. Cognitive/Psychological: *(Changes in orientation, memory, ability to resolve problems, depression, mental health, response to losses, significance of current problems to client)*

8. Social Network: *(Family, friends, quality or relationships, losses, leisure activities)*

9. Abuse: *(Evidence of abuse, neglect, and exploitation)*

10. Finances: *(Entitlements, ability to manage own affairs, problematic expenses, indication of exploitation or mismanagement)*

11. Services: *(Include purchased and referred services in place at time of assessment; services refused)*

12. Client Concerns: *(What the client and family want from Linkages)*

13. Indications for Care Management:

Client's Signature(s) _____Title _____Date_____

Case Manager Signature:_____ Title_____ Date_____

III B- Supportive Services Program (SSP) Program Care Plan

Client's Name:		Client #:		Care Plan Date:		Time provided:
				Re-Assessment Date:		Time provided:

Client Issues: ***Circle all items that apply to this care plan*.**

A. Advanced Directives	H. Grief/Death/Dying	O. Mental Health
B. Adjustment to Health	I. Home Safety	P. Nutritional Concerns
C. Caregiver Needs	J. Impaired Mobility	Q. Placement/Living Arrangements
D. Chemical Use	K. Insurance Issues	R. Socialization
E. Depression	L. Legal/Financial	S. Transportation
F. Elder Abuse	M. Med Equip/Supplies	T. Medical Care
G. Family Coping/Stress	N. Medications	U. Other:_____

Date	Problem Statement	Desired Outcome/Goal	Plan/Intervention/Service Arranged	Date Resolved/ Status

Staff Signatures:			
Care Planner:	**Date:**	**Supervisor**	**Date:**

I acknowledge receipt and acceptance of this Care Plan.	***x***
	Client Signature **Date**

III B- Supportive Services Program (SSP) Program

Case Management Arranged Services Code

SERVICE CATEGORY AND CODE DESIGNATIONS AND DEFINITIONS		
NUMERIC CODE	SERVICE CATEGORY DESCRIPTION	UNIT OF MEASURE
31	**Adult Day Care** - Community-based centers that provide non-medical care to Clients requiring a variety of social, psychosocial, and related support services, and for adults in need of personal care services, supervision, or assistance essential for sustaining the activities of daily living services are provided in a protective setting on less than a 24-hour basis.	# of Hours
32	**Alzheimer's Day Care Resource Center** - Community-based centers that provide day care for Clients in the moderate to severe stages of Alzheimer's Disease or other related dementias, and provide various resource services for family caregivers and the community-at-large.	# of Days
33	**Adult Day Health Care** - Provides personal care, nutrition, therapy, health care, socialization, and recreation to Clients in a licensed facility.	# of Hours
34	**Respite** - Provides supervision and care of Clients while the person(s), who normally provides full-time care, takes short-term relief or respite.	# of Hours
35	**Transportation** - Provides Client transportation services, including bus, dial-a-ride and cab, to various health appointments and social resources. Transportation provider must have valid vehicle insurance and a valid and appropriate California Drivers License.	# of One Way Trips

36	**Housing Assistance** – Provides assistance to Clients in securing living arrangements. Provides minor home repairs or permanent modifications; e.g., permanent ramp, widening doorways necessary to accommodate physical limitations; minor renovation, installation, or maintenance for accessibility, safety, or security; includes pest control services; home finding services; and moving costs. Provides for repair of home equipment, appliances and supplies necessary to assure Client's independence. Provides for a regular telephone, for rent or house payments, deposits for new rental, and home insurance payments; provides for emergency, unusual, or ongoing utility costs, including installation and monthly telephone service charges (If more than one-time-only, requires prior authorization from the CSS Director or designee of the COUNTY). Provides for temporary housing or relocation of Client. Activities may include equipment and labor necessary for the move. **Example:** If the care manager arranges to purchase or arrange a regular telephone and a permanent ramp then that is two occurrences. Installation would be included unless a separate provider is used to install and then that would be counted as a separate occurrence. **Examples of units of service**: Location of housing : 1 living arrangement made equals 1 occurrence Arranging a move: 1 move equals 1 occurrence Pay utilities: 1 month per utility equals 1 occurrence Pay first and last month rent: 2 months equals 2 occurrences Home and Energy Assistance Program (HEAP) payment: 1 payment equals 1 occurrence	# of Single Occurrences
37	**Congregate Nutrition** – Provides meals to Clients who are able to secure meals at a congregate nutrition site. CONTRACTOR shall arrange or serve a meal to a Client in a congregate group setting by a Title III C-1 Nutrition Service Provider.	# of Meals
38	**Home-Delivered Nutrition** - Provides home-delivered meals for homebound Clients who are unable to prepare their own meals or do not have someone who can prepare their meals. CONTRACTOR shall purchase services from a Title III C-2 Nutrition Service Provider.	# of Meals
39	**Assistive Devices** – Provides for rental or purchase and monthly fee service of electronic communication devices, emergency response equipment, and similar equipment to provide Client access to immediately contact First Responders (does not include regular telephones but adaptive phone equipment which is provided to the disabled). Provides for the installation of smoke detectors, portable ramps, and grab bars. Provides for items such as body braces, orthopedic shoes, walkers, wheelchairs, and installation of safety devices in the home.	# of Single Occurrences

	Example: If the care manager arranges for or purchases a grab bar and a portable ramp then that is two occurrences. Installation would be included unless a separate provider is used to install and then that would be counted as a separate occurrence.	
40	**Assisted Transportation** – Provides one-to-one Client escort transportation services to a Client who has physical and/or cognitive difficulty using regular vehicular transportation. Client may be transported to various health appointments and social resources. Transportation providers must have vehicle insurance and a valid and appropriate California drivers License.	# of One Way Trips
41	**Legal Assistance** –Consists of legal representation and other administrative functions, to at risk clients, 18 years of age and older, with unmet legal needs, by members of the California State Bar, or by a non-attorney, paralegal or law student, under the supervision and control of a member of the California State Bar. Legal representation shall be provided to at risk clients, 18 years of age and older, in the community, as well as to home-bound, and/or isolated. Such services may include: assistance with legal forms and documents; consumer protections; consultation; mediation, and advice. May include assistance with durable power of attorney for health care or other advance directives. Also, provides for legal representation and/or advocacy before an administrative or judicial tribunal only by a licensed attorney with the California State Bar.	# of Hours
42	**Special Needs –** Provides a Client food staples, when the Client is functionally impaired by virtue of a special circumstance that has occurred within the past twelve (12) months; may include restaurant purchased meals when special circumstances necessitate the purchase; and food stamps for eligible Clients under special circumstances. Provides for interpreter/translator services. Provides for essential clothing, toiletries, and similar personal care items for use in the home. **Examples of units of service:** Shopping: 1 trip or delivery equals 1 occurrence Translation: 1 session/visit equals 1 occurrence Brown Bag: 1 delivery equals 1 occurrence	# of Single Occurrences
43	**Employment/Recreation/Education –** Provides for expenses for employment development, recreational, and educational activities, and supplies for participation in job training, work activity, rehabilitation, and self-improvement. Provides for specialized training including training in Braille, sign language, driver education, etc., in addition to in-home and community skills training.	# of Single Occurrences

	Examples of units of service: Membership in sports club: 1 month equals 1 occurrence Recreational trips: 1 trip equals 1 occurrence Job training: 1 course equals 1 occurrence Driver's education: 1 course equals 1 occurrence Braille or sign language: 1 course equals 1 occurrence In-home and community skills training: 1 visit equals 1 occurrence	
44	**Medical Services** – Provides physician, nursing care, therapy, health aide services, and medical social services. Private health professionals should be California State licensed or certified. Provides for filling or refilling of prescriptions. Provides for medications prescribed by a physician that are not covered by Medi-Cal or other services. Also includes medi-sets (containers that store a daily/weekly dose of medications) and over-the-counter items such as incontinence supplies, vitamins, aspirin, etc., essential to the Client's well being. **Examples of units of service:** Nutritional supplement or incontinence supplies: 1 delivery equals 1 occurrence Prescriptions/over the counter/vitamins: 1 delivery equals 1 occurrence Nurse, therapist, physician: 1 visit equals 1 occurrence	# of Single Occurrences
45	**Protective Services** – Provides supervision or protection for Clients who are unable to protect their own interests or whose income or resources are being exploited; who are harmed, threatened with harm, neglected or maltreated by others, or caused physical or mental injury as a result of an action or an inaction by another person or by their own actions due to ignorance, illiteracy, incompetence, or poor health; who are lacking in adequate food, shelter, or clothing; and who are deprived of entitlement due them. Provides information about money management and financial resources such as financial counseling and assistance, and legal and medical assistance so that the Client is able to relate to establishing a conservatorship. Services may be provided by private, profit, or non-profit agencies, and a substitute payee may be full-time or provide services on a periodic basis. **Example of units of service:** Money management :1 session or visit equals 1 occurrence Representative payee: 1 month of service equals 1 occurrence Adult Protective Services: 1 visit/contact equals 1 occurrence	# of Single Occurrences
46	**Social and Reassurance –** Provides telephone contact, friendly visitors, and other reassurance services by a party or agency other than a Care Manager. **Examples of units of service:** Telephone contact = 1 phone call equals 1 occurrence	# of Single Occurrences

	Visitation = 1 visit equals 1 occurrence	
47	**Personal Care –** Provides assistance with non-medical personal services such as bathing, hair care, etc.	# of Hours
48	**Homemaker** – Provides household support such as cleaning, laundry (including commercial laundry or dry cleaning firm), shopping, food preparation, light household maintenance (changing light bulbs, furnace filters, etc.).	# of Hours
49	**Chore** – Provides periodic maintenance for chores, such as heavy cleaning, washing windows, trimming trees, mowing lawns, and removal of rubbish and other substances to assure hazard free surroundings.	# of Hours
50	**Counseling –** Group and/or individual counseling, including peer counseling, that may include biofeedback, substance abuse, etc., or therapeutic counseling.	# of Sessions

III B- Supportive Services Program (SSP) Progress Notes ATTACHMENT 9

Client Name:	ID #:

Date, Time (in Hours and Minutes), and Code.	Narrative	**Case Manager**
Date: _____ Time: _____ Care Plan #: _____ Mode: _____		
Date: _____ Time: _____ Care Plan #: _____ Mode: _____		
Date: _____ Time: _____ Care Plan #: _____ Mode: _____		
Date: _____ Time: _____ Care Plan #: _____ Mode: _____		
Date: _____ Time: _____ Care Plan #: _____ Mode: _____		

1) Care Plan # must align with Care Plan Problem # under Form SSP-CMF5 Care Plan.

2) Mode Code Key: TC-Telephone Call, VM - Voice Message, HV – Home Visit (Conducted once every six (6) months.). Traveling time to and from Client's home and VM is not billable but may be used as matching. All TC and HV shall be tracked by the actual time Services were provided directly (live contact) to the Client and are NOT rounded to the next whole hour. Actual time shall be determined by the decimal value for a portion of an hour, the actual minutes of Service shall be divided by sixty minutes. As an example, 30 minutes would be reflected in the MIS as .5 units. (30/60=.5).

Reviewed and Approved by Project Director/Manager Signature _____ Date: _____

ATTACHMENT 9

III B- Supportive Services Program (SSP) Program
REASSESSMENT SUMMARY

These are general guidelines: include only information that is pertinent to develop and support a care plan. Focus on changes. It is not necessary to include information in more than one section of the summary - place it where it has most relevance.

Client Name: _____ ID No.:_____ Date:_____

1. Client Description: *(Age, living arrangement, physical appearance and presentation)*

2. Health: *(Diagnosis; changes in general health status, health practices, medical compliance, nutrition, continence, problematic signs or symptoms, frequency and adequacy of health care)*

3. Medications: *(Medication use/interactions, ability to self manage)*

4. ADL/IADL Functioning Levels: *(Changes in ambulatory status, functional abilities, assistive devices, areas of unmet need; support for LOC finding)*

5. Caregiver: *(Formal and informal support, reliability and skill level of caregiver, degree of caregiver stress, evidence of caregiver health or financial problems)*

6. Environmental Safety: *(Adequacy of home; safety and accessibility consideration*

ATTACHMENT 9

III B- Supportive Services Program (SSP) Program
REASSESSMENT SUMMARY

Client Name: _____ ID No.:_____ Date:_____

7. Cognitive/Psychological: *(Changes in orientation, memory, ability to resolve problems, depression, mental health, response to losses, significance of current problems to client)*

8. Social Network: *(Family, friends, quality or relationships, losses, leisure activities)*

9. Abuse: *(Evidence of abuse, neglect, and exploitation)*

10. Finances: *(Entitlements, ability to manage own affairs, problematic expenses, indication of exploitation or mismanagement)*

11. Services: *(Include purchased and referred services in place at time of assessment; services refused)*

12. Client Concerns: *(What the client and family want from Linkages)*

13. Indications for Care Management:

Client's Signature(s) _____Title _____Date_____

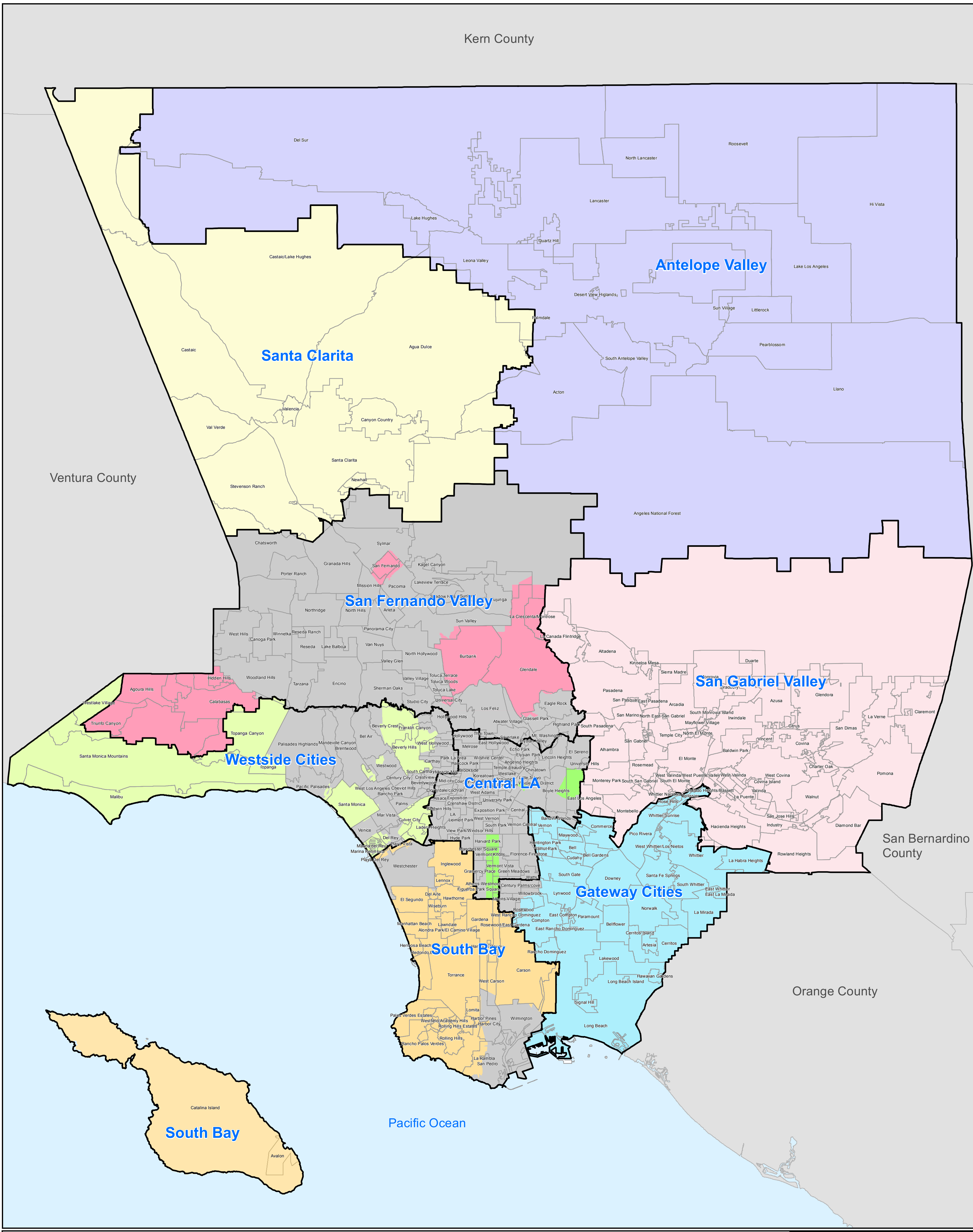
Case Manager Signature:_____ Title_____ Date_____

Attachment 10
AAA Service Provider Referrals

Service Region	Family Caregiver Support Program (FCSP) and Grandparents/Relative (GR) Program		
	Agency	**Address**	**Phone Number**
Antelope Valley	Santa Clarita Valley Committee in Aging	22900 Market Street, Santa Clarita, CA 91321	(661) 259-9444
Gateway Cities	The Family Caregiver Resource Center (LACRC), USC School of Gerontology	3175 McClintok Avenue, Los Angeles, CA 90089	(855) 872-6060
San Gabriel Valley	The Family Caregiver Resource Center (LACRC), USC School of Gerontology	3175 McClintok Avenue, Los Angeles, CA 90089	(855) 872-6060
Santa Clarita Valley	Santa Clarita Valley Committee in Aging	22900 Market Street, Santa Clarita, CA 91321	(661) 259-9444
South Bay	WISE and Healthy Aging	1527 4th Street, 2nd Floor, Santa Monica, CA 90401	(310) 394-9871
Central Los Angeles	The Family Caregiver Resource Center (LACRC), USC School of Gerontology	3175 McClintok Avenue, Los Angeles, CA 90089	(855) 872-6060
San Fernando Valley	Santa Clarita Valley Committee in Aging	22900 Market Street, Santa Clarita, CA 91321	(661) 259-9444
Westside Cities	WISE and Healthy Aging	1527 4th Street, 2nd Floor, Santa Monica, CA 90401	(310) 394-9871
Serving All Workforce Regions	**Dietary Administrative Support Services (DASS) Program**		
	Consulting Nutritional Services	31225 La Baya Drive, Suite 201, West Lake Village, CA 91362	(818) 874-9626

ATTACHMENT 10

Los Angeles County Area Agency on Aging Service Regions



Legend

Regions

Surrounding counties	Antelope Valley	San Fernando Valley	South Bay
LA City	Central LA	San Gabriel Valley	Westside Cities
	Gateway Cities	Santa Clarita	

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Miles

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*Please note that Catalina Island is not to scale.

*Zip code boundaries and names are established by the U.S. Postal Service (USPS). Zip code boundaries do not necessarily follow established municipal, community, and other district boundaries. Therefore, while a zip code name usually reflects the municipality or communities that predominates that area, it does not necessarily coincide entirely with the established municipal, community, or other district boundaries. Thus, a zip code name may include parts of other communities and/or districts not reflective of its name.

Workforce Development, Aging and Community Services, Research & Statistics Division *3/15/2017*